STATE OF IOWA
FAMILY AND MEDICAL LEAVE ACT (FMLA)
APPLICATION

TO BE COMPLETED BY EMPLOYEE AND PERSONNEL ASSISTANT (please print or type)

Employee Name: _____ SSN: _____

Department: _____ Payroll No: _____

Bargaining Unit: _____ Status: _____

My spouse is employed by the State of Iowa, Check (✓) one: ☐ yes ☐ no
If yes, name the department and verify the number of hours used (if any): _____

_____

Check (✓) the Appropriate Box

MEDICAL LEAVE ☐ (employee's serious health condition)

Illness, Injury, or Condition: _____

FAMILY LEAVE ☐ (family member's serious health condition, or the birth, adoption or foster placement of the employee's child)

Family Member Name: _____

Date of Birth: _____ Relationship: _____

Illness, Injury, or Condition: _____

From: _____ **To:** _____

(Date - must be included to process your application) *(Date - if known, indicate if unknown)*

Certification of physician or practitioner must accompany this form, except in the case of a birth, adoption or foster placement. However, completion of this form is required. Employee may be required to supply further medical documentation. You will be required to provide your employer with a written "fitness for duty" certification either prior to or within five calendar days after you return to work.

I understand that during FMLA leave (12 weeks maximum per fiscal year), I am required to pay my share of insurance premiums for which I am ordinarily responsible. If premiums are not paid within 30 calendar days of the coverage month, my insurance will be retroactively canceled. I acknowledge that, if I do not return from FMLA leave due to reasons not provided in the Family and Medical Leave Act, I am required to reimburse any premiums paid by the State of Iowa for my insurance while I am on approved FMLA leave. If reimbursement is not made, insurance coverage will be canceled retroactively the first of the month following exhaustion of paid leave.

I give my employer permission to obtain clarification from my health care provider, check (✓) one: ☐ yes ☐ no

I intend to return to work, check (✓) one: ☐ yes ☐ no ☐ unknown

Employee Signature: _____ Date: _____

Supervisor Approval: _____ Date: _____

Personnel Assistant Verification: _____ Date: _____

Personnel Assistant Telephone Number: (_____) _____

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EXTENSION of Request (if 12 week maximum per fiscal year is not exhausted). Additional Medical Information May Be Required:

From: _____ (Date) **To:** _____ (Date)

Employee Signature: _____ Date: _____

The employee named is granted the extension of FMLA leave requested. All stated information remains accurate.

Supervisor Signature: _____ Date: _____

TRACKING

To be completed by the personnel assistant (please print or type)

1. FMLA leave used to date: _____
   (If employee has previously been approved for FMLA leave during the current fiscal year, enter the number of hours previously utilized [from (6) on last FMLA leave tracking form].)

2. Last date worked: _____ 2a. FMLA start date: _____
   (Enter the last date the employee was actively working and the date FMLA leave started.)

3. Last date in paid status: _____ 3a. Hours of paid FMLA leave: _____
   (Enter the last date the employee was in pay status [if applicable] and the total hours of paid FMLA leave.)

4. Returned to work: _____ 4a. Hours of unpaid FMLA leave: _____
   (When employee returns from leave enter the date returned [if applicable].) (Enter the total hours of unpaid FMLA leave [if applicable]).

5. FMLA leave expired: _____
   (If the employee did not exhaust the 12 week maximum, go to number six. If the employee did exhaust the 12 week maximum, enter the date and hour in which it terminated [see calculation worksheet below to determine the maximum number of hours available per fiscal year].)

6. Total FMLA leave used: _____
   (Enter the total number of FMLA leave hours [paid and unpaid] used this fiscal year.)

_____ (Average Number of Hours Per Week) X 12 (weeks) = _____ (Total Number of FMLA Leave Hours Available)

NOTE: If average number of hours per week is under 30, the employee is not eligible for life and disability insurance. If average number of hours per week is under 20, the employee is not eligible for health and dental insurance.

PLEASE USE THE TABLE BELOW TO TRACK FMLA LEAVE USAGE

Pay Period	Hours Worked	FMLA Leave Used This Pay Period	FMLA Leave Used This Fiscal Year